THE HENRY J. KAISER FAMILY FOUNDATION

Analysis of Benefits Offered By Medicare HMOs, 1999: Complexities and Implications

Prepared by,
Barents Group LLC

August 1999

ANALYSIS OF BENEFITS OFFERED BY MEDICARE HMOs, 1999: COMPLEXITIES AND IMPLICATIONS

Prepared by:
Barents Group LLC

Prepared for:
The Henry J. Kaiser Family Foundation

August 1999

ANALYSIS OF BENEFITS OFFERED BY MEDICARE HMOs, 1999: COMPLEXITIES AND IMPLICATIONS

Prepared by:

Kathryn Langwell
Christopher Topoleski
Daniel Sherman*

Barents Group LLC

Prepared For:
The Henry J. Kaiser Family Foundation

August 1999

*Previously with Barents LLC and now with the American Institutes for Research

This report was commissioned by the Henry J. Kaiser Family Foundation (grant # 97-1243). The views expressed in this report are those of the authors and do not necessary reflect those of the Foundation.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Medicare HMOs offer benefits, such as prescription drug and dental coverage, beyond those offered under the traditional Medicare program, usually without the requirement that beneficiaries pay an additional premium. The availability of supplemental benefits makes HMOs attractive to many Medicare beneficiaries, in that they directly reduce the costs to beneficiaries of services generally not covered by the Medicare program. Thus, the number of Medicare beneficiaries enrolled in Medicare HMOs has grown almost fourfold in the past three years, from 1.8 million in December 1995 to almost 6.2 million in May 1999, or about 15 percent of all Medicare beneficiaries.

This study uses *Medicare Compare*, a Health Care Financing Administration database with relatively detailed information on basic and supplemental benefits offered by Medicare HMOs in their "basic" plan, to analyze the details of supplemental benefits offered and premiums charged, in 1999, by Medicare HMOs nationwide. The study assesses the generosity of selected benefits and the variation in benefits within and across markets. It also examines the implications of benefit variations on out-of-pocket spending for beneficiaries enrolled in Medicare HMOs, using illustrative examples.

Findings

The level of monthly premiums charged by Medicare HMOs, and the generosity of many supplemental benefits, varies widely.

Premiums. There is significant variation in premiums across HMOs. Most Medicare HMO enrollees (64 percent) are not charged a premium for the HMO's "basic" package; about 2 percent pay $10 or less per month while 11 percent are in HMOs that charge more than $45 per month, with an average premium of $15.50 per month.

Physician and Other Medicare Required Services. Cost-sharing requirements for benefits covered under the traditional Medicare program tend to be similar across Medicare HMOs. For example, virtually all beneficiaries (96 percent) are not required to make per episode hospital copayments and 99 percent of beneficiaries are covered for 100 percent of the costs of SNF use up to 100 days. There was wide variation in copayment requirements for primary care physician office visits in 1999, however, with per-visit copayments ranging from $2 to $20 across plans, with an average copayment of $5.94 per visit. In general, copayment requirements for specialist visits are similar to that for visits to primary care physicians. The average copayment for specialist visits is $6.37.

Prescription Drugs. More than 8 of 10 Medicare HMO enrollees are in a plan that offers prescription drug benefits under the "basic" plan, but maximum annual drug limits vary widely. Nearly a quarter of all Medicare HMO enrollees with a drug benefit are in a plan that does not limit coverage, while 11 percent of those with drug coverage are in a plan with drug limits below

$600. About a third (31 percent) of Medicare HMO enrollees with drug coverage are in plans with annual drug limits that are greater than $1,000, with an average annual limit of $1,149.

The average generic copayment per prescription (in HMOs that offer a prescription drug benefit in their "basic plan") is $6, with most beneficiaries enrolled in HMOs that charge between $5 and $10 per prescription. Copayment requirements for brand name drugs are higher than for generic drugs; with an average copayment of $13 per prescription.

Hearing aids. The provision of hearing aids is a complex benefit in which HMOs impose various mixes of the number of units that may be purchased over a specified time period, the maximum amount that the plan will pay, and the share of total cost that the plan will cover. For example, some Medicare HMOs will pay 50 percent of the cost of one hearing aid annually, while others may impose an annual limit (e.g. $250) on HMO payment for hearing aids.

The generosity of many benefits, especially prescription drug coverage, and the level of premiums charged by HMOs, vary widely within and across markets.

Most beneficiaries (61 percent) live in an area with two or more Medicare HMOs, and, thus, can choose among plans offering different benefit packages. Based on an examination of six specific counties across the United States, selected because they have a large number of Medicare beneficiaries and high levels of Medicare HMO enrollment, we found the generosity of benefits and level of premiums vary substantially within and across markets. [1].

Within Market Areas. Monthly premiums and supplemental benefits in the basic plan offered by Medicare HMOs *within* market areas often differ significantly. Premiums in Cook County, Illinois, for example, range from $0 per month to $63 per month. Annual prescription drug benefits in Los Angeles County, while offered by all Medicare HMOs, vary from $2,000 per year to 'unlimited' annual drug benefits. Copayments for brand-name drugs in Maricopa, AZ. range from $5 to $15 per prescription. The copayment requirements for hearing exams in Dade County range from $0 to $25. In Allegheny County, PA, the hearing aid benefit ranges from $500 every two years to $500 every three years.

Across Market Areas. Benefits offered under Medicare HMOs' basic plans also vary significantly *across* market areas. In Los Angeles, Dade and Maricopa County, none of the plans impose supplemental premiums, in contrast to plans in Cook, Allegheny and King County. In Dade County, FL, nine of 10 Medicare HMOs offer 'unlimited' drug coverage, compared with King County, WA, where none of the seven plans offer prescription drug coverage.

[1] Los Angeles County, CA; Dade County, FL; Maricopa County, AZ; Cook County, IL; Allegheny County, PA; and King County, WA

Variations in benefit design can expose beneficiaries to complex choices and have a significant impact on out-of-pocket spending.

To illustrate the effects of benefit design and generosity on out-of-pocket spending for prescription drugs and hearing aids, we constructed profiles of 'typical' Medicare beneficiaries.

Our analysis of potential out-of-pocket liability of an illustrative Medicare beneficiary with multiple health conditions requiring high use of prescription drugs indicates that, in the typical "least generous" HMO, she would incur out-of-pocket costs of $5,358 for prescription drugs, with the HMO paying a maximum amount annually of $600. In the typical "most generous" HMO, with no annual maximum, this enrollee would pay $1,080 out-of-pocket and the HMO would pay $4,878. The difference in out-of-pocket costs, depending on the HMO chosen by this beneficiary, is over $4,300. An illustrative Medicare beneficiary with moderate prescription drug requirements would incur over $2,700 in out-of-pocket costs in the "least generous" HMO, but only $600 in out-of-pocket costs in the "most generous" HMO.

Analysis of out-of-pocket liability for hearing aid costs for an illustrative Medicare beneficiary requiring two hearing aids a year at a cost of $1,100 each indicates that the beneficiary would incur $1,450 in out-of-pocket costs in the "least generous" HMO offering the benefit and $1,100 in costs in the "most generous" HMO offering the benefit.

These results illustrate the potential differences in liability that beneficiaries face (and must evaluate) in choosing among Medicare HMOs available to them.

Discussion

By law, all Medicare HMOs must offer basic Medicare benefits. Most offer a complex package of supplemental benefits, in addition to required Medicare benefits. These supplemental benefits are attractive to Medicare beneficiaries who often face significant out-of-pocket liability for these services. The analysis of selected benefits offered by Medicare HMOs in 1999 indicates that there are wide variations in the coverage for supplemental benefits that are offered. Medicare beneficiaries who must choose among HMOs and between HMOs and other supplemental insurance policies are faced with a complicated task in evaluating their choices and their implications for out-of-pocket spending.

The scope of prescription drug benefits offered by Medicare HMOs varies widely across plans. More than one in six Medicare HMO enrollees are in a plan without any drug coverage, while one in four are in a plan with an unlimited drug benefit. At a time when prescription drug costs are rising rapidly, the more generous Medicare HMOs may be the best alternative available to many Medicare beneficiaries facing high out-of-pocket costs for needed medications. The rapid increases in prescription drug costs, coupled with reductions in the growth of Medicare payments to plans, may place increasing financial pressures on Medicare HMOs, potentially jeopardizing the availability of relatively generous, affordable drug coverage under Medicare HMOs in the future.

Results of the study provide useful information for the current policy discussions about the complexities of choices available to Medicare beneficiaries and the information they need to make appropriate choices. In addition, it highlights the uneven availability of highly desired benefits under Medicare HMOs throughout the nation.

INTRODUCTION

The number of Medicare beneficiaries enrolled in Medicare HMOs has grown almost fourfold in the past three years, from 1.8 million in December 1995 to almost 6.2 million in May 1999, or about 15 percent of all Medicare beneficiaries. Medicare HMOs have sought to attract Medicare beneficiaries by offering benefits, such as prescription drug and dental coverage, beyond those offered as part of the traditional Medicare program, usually without the requirement that beneficiaries pay an additional premium. For the past several years, a growing number of plans have elected to offer supplemental benefits as part of their basic plan.[2] The availability of supplemental benefits makes HMOs attractive to many beneficiaries, in that plans directly reduce the costs to beneficiaries of services generally not covered by Medicare.

In choosing to enroll in a Medicare HMO, beneficiaries are expected to assess the value of the "package" of benefits that they are offered by HMOs in their area and to evaluate these plans relative to other options, such as traditional Medicare supplemented by a Medigap plan. There is some expectation that beneficiaries will examine and compare copayment requirements, plan maximums, and deductibles to understand key differences that could affect their coverage and financial liability. However, selecting a Medicare HMO is not necessarily easy, in that there is a great deal of variability in benefits, and associated cost-sharing requirements. Unlike Medigap products which offer beneficiaries a limited number of options with clearly defined benefits and cost-sharing requirements, the structure of supplemental benefits offered by Medicare HMOs typically varies from plan to plan. These differences can have a significant impact on beneficiary out-of-pocket spending.

The issue of the complexity of health plan benefit offerings has recently become more important from a policy context. The Balanced Budget Act of 1997 (BBA 97) made significant changes in the methodology used by HCFA to pay HMOs for enrolling Medicare beneficiaries beginning in 1998 and introduced additional reporting and administrative requirements for Medicare managed care plans. Under the BBA 97, increases in payments have been reduced in areas in which payments have historically been high and where enrollees have received relatively generous supplemental benefits with little or no additional premiums. In addition, HCFA will begin risk adjusting payments to Medicare managed care plans beginning in 2000 that is expected to further reduce payments for many HMOs. As a result, it is likely that these Medicare HMOs have felt (and will continue to feel) financial pressure to reduce benefits and increase member copayments and premiums. Changes in Medicare HMO benefits over time will make it even more important for beneficiaries to review benefits and cost-sharing requirements to understand and compare out-of-pocket expenses across plans in their area.

---

[2] Gold, Marsha, Amanda Smith, Anna Cook, and Portia Defilippes. *Medicare Managed Care: Preliminary Analysis of Trends in Benefits and Premiums, 1997-1999.* Mathematica Policy Research, Incorporated, June 1999.

The purpose of this paper is to examine the scope of benefits offered by Medicare HMOs in their basic plan. It examines the various features of Medicare HMO benefits – primarily focusing on cost-sharing requirements – to highlight the complexity of these offerings and the difficulty that Medicare beneficiaries may have in choosing among the Medicare managed care plans that serve their communities. This analysis uses data from HCFA's *1999 Medicare Compare* database and other sources to describe current features of available benefits and show the degree of variation that exists across health plans.

Methods

To date, there has been relatively little research that describes the supplemental benefits available to Medicare HMO enrollees other than information on whether various benefits are offered. Analyses of HMO benefits, both standard Medicare benefits and supplemental HMO offerings, have historically relied on HCFA's Monthly Report of Prepaid Health Plans. Benefit data from HCFA's Monthly Report of Prepaid Health Plans prior to January 1999 was dichotomous with respect to reporting benefits.[3] The report simply presented a 'yes' or 'no' indicator to the question of whether or not a plan offered a given benefit. These data did not permit assessment of the generosity or limits on benefits or estimates of Medicare beneficiaries' potential out-of-pocket liability for specific benefits in different HMOs. With the introduction of the Medicare Compare website in late 1997, beneficiaries and researchers were for the first time provided with more detailed information on copayment requirements and limits on specific benefits.

The Medicare Compare Internet database (www.medicare.gov) was set up in late 1997 and has subsequently been revised for 1998 and 1999 [4] The database contains information on 24 categories of services offered by each Medicare+Choice plan as well as traditional fee-for-service Medicare and the various categories of Medigap insurance (A-J). These benefits include the basic Medicare coverage required by law as well as information on any supplemental benefits offered by Medicare+Choice plans. The entire database can be downloaded, or can be used interactively allowing users to make queries regarding the features of specific types of benefits for a given state, county, or zip code to compare benefits across plans. HCFA does not provide data on enrollments in each package that a plan may offer.

The paper focuses on benefits for which there is significant variation in cost-sharing requirements, and sufficient information on Medicare Compare to assess variations in benefit structures across plans. Our preliminary analysis found minimal variation in most benefits covered under the traditional Medicare program, with the exception of cost-sharing for physician services. This study thus examines cost-sharing requirements for physician care and for

[3] Beginning in January 1999, all benefit information was dropped from the report, presumably because Medicare Compare exists with an explicit purpose of reporting benefits, both standard Medicare and supplemental HMO offerings.

[4] The 1997 data in Medicare Compare were generally incomplete and inconsistently coded, though data for subsequent years have been more complete and contain information consistent with other HCFA data sets.

supplemental benefits, including prescription drugs, preventive dental services, hearing exams and hearing aids.[5]

A particular focus of this study is detailed examination of the prescription drug benefits offered by Medicare HMOs to beneficiaries. Prescription drug benefits are often used in Medicare HMO marketing materials to attract new enrollees, and are cited by beneficiaries as a major reason for joining a Medicare HMO.[6] Prescription drug costs have been rising rapidly in recent years, in part because of the introduction of new and more effective products. Because outpatient prescription drug benefits are not offered by Medicare the availability of drug coverage through Medicare HMOs is one of the attractive features of joining these plans. [7] However, it is possible that the changes in Medicare payments to HMOs, combined with the rising costs of prescription drugs, may cause HMOs to reduce or eliminate these benefits in future years. The analysis in this paper is intended to describe current prescription drug coverage through HMOs in order to asssess the range in the generosity of benefits and the effects of different drug limits on out-of-pocket spending.

The analysis of the features of benefits and premiums reported in this paper is based on the "basic plan" offered by Medicare managed care plans. Medicare HMOs may offer "high option" benefit plans, as well as the "basic plan." HCFA data sets report do not provide information on the number of a plan's members who are enrolled in the "basic" plan versus "high option" benefit plans. Thus, the analysis reported here should be interpreted as indicating the number of Medicare beneficiaries who are enrolled in Medicare managed care plans that offer the benefits described in their "basic" plan. Some of these enrollees may have chosen a "high option" plan and are paying a higher supplemental premium for a more generous set of benefits.

In presenting data on premiums and the characteristics of benefits, we have computed the share of enrollees in health plans that offered a benefit with a certain characteristic (e.g., a $5 copayment for prescription drugs) under their "basic package." This allows us to account for the possibility that characteristics of benefits may differ across HMOs of different size. By accounting for the variation in plan enrollment, these weighted figures provide a better indication of the distribution of benefits with different characteristics among those beneficiaries who were enrolled in Medicare HMOs in 1999.

[5] While vision care services and eyeglasses were also of interest, the Medicare Compare data base does not provide detail on these benefits.

[6] Neuman, P. E. Maibach, K. Dusenbury, M. Kitchman, and P. Zupp, "Marketing HMOs to Medicare Beneficiaries," Health Affairs (July/August 1998): 132-139.

[7] The Administration has proposed the addition of a prescription drug benefit to Medicare which, when fully phased in by 2008, would pay a maximum of $2500 – 50 percent of an individual beneficiary's prescription drug costs up to $5000.)

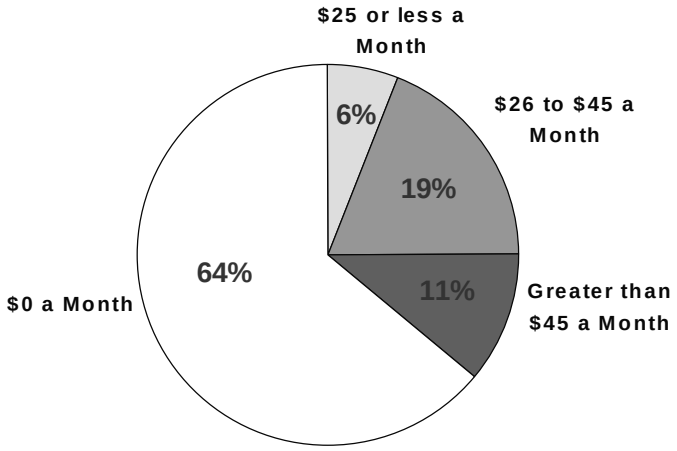
DESCRIPTION OF PREMIUMS AND BENEFITS AVAILABLE TO MEDICARE BENEFICIARIES ENROLLED IN MEDICARE HMOs

The analysis of benefits offered by Medicare HMOs in 1999 shows wide variation in the premiums charged to beneficiaries, and the generosity of many supplemental benefits, especially potentially high-cost benefits, such as prescription drugs and hearing aids.

Supplemental Plan Premiums

The range of monthly "basic plan" premiums (above the Part B premium) charged by plans to beneficiaries is presented in Exhibit 1. Nearly two-thirds (64 percent) of Medicare HMO enrollees are in HMOs that provide reduced cost-sharing and supplemental benefits to their enrollees at no additional premium, and 89 percent of beneficiaries are enrolled in plans that charge less than $45 a month. However, the range of premiums charged, for plans charging a supplemental premium for their "basic plan," is quite large, from $9 in some plans to $250 a month in others. In addition to examining the share of risk enrollees charged a premium, it is also of interest to describe the premium *amounts* that beneficiaries pay. There are two ways to measure this amount. The first measure is the average premium paid by beneficiaries, excluding those who do not pay a premium, yielding a monthly premium of $41.37 a month. Alternatively, the average for beneficiaries across *all* plans, including those who are enrolled in plans that charge no premium for their "basic" package, is $15.50 a month.

Exhibit 1: Supplemental Premium Requirements for Medicare Managed Care Enrollees in "Basic Plan," 1999



Note: Mean Premium for all beneficiaries: $15.50; Mean premium for only beneficiaries charged a premium: $41.37; 5.95 million Medicare beneficiaries enrolled in 279 plans.
SOURCE: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999.

Copayments for Physician Office Services

Most (81 percent) of all Medicare beneficiaries are enrolled in HMOs that require that their enrollees to make a copayment for primary care physician office visits in 1999 under their "basic plan" package. Two-thirds of enrollees paid between $5 and $10 for each primary care office visit (Exhibit 2). There was wide variation in copayment requirements, however, with per-visit copayments ranging from $2 to $20 across plans and an average copayment of $5.94 per visit.

In general, copayment requirements for specialist visits are similar to those for visits to primary care physicians. The average copayment for specialist visits is $6.37. Copayments for specialist visits varied from $3 per visit to $25 per visit, under HMO "basic plans."

Exhibit 2: Percent of Enrollees in HMOs, by Copayment Charged Per Visit Under the "Basic Plan," 1999

		Required Copayment Per Visit					
		$0	Up to $5	$5	$6 to $10	Greater than $10	Total
Percent of HMO Enrollees by Primary Care Physician Copayment Charged		19%	7%	35%	32%	7%	100%
Mean Copayment	$5.94						
Minimum Copayment	$0						
Maximum Copayment	$20.00						
Percent of HMO Enrollees by Specialist Physician Copayment Charged		24%	4%	33%	27%	13%	100%
Mean Copayment	$6.37						
Minimum Copayment	$0						
Maximum Copayment	$25.00						

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999; 6,126,199 Medicare beneficiaries enrolled in 285 plans.

Prescription Drugs

Outpatient prescription drugs are generally not a covered Medicare benefit, and Medicare HMOs often feature the availability of this benefit prominently in their marketing materials. The availability of outpatient prescription drug benefits offered by Medicare HMOs is particularly of interest, since prescription drug costs are rising much faster than overall medical care costs. Medicare does not cover the cost of outpatient prescription drugs, although there have been a number of initiatives that would modify Medicare to cover some outpatient prescription drug costs. However, at present, Medicare beneficiaries who wish to purchase outpatient prescription drug coverage have limited options for coverage under relatively expensive 'high option' Medigap plans or they may join a Medicare HMO that offers a prescription drug benefit.

Currently 83 percent of plans in the Medicare Compare database offer some type of prescription drug benefit. These benefits have a number of features, including copayments, maximum annual limits, and drug formulary restrictions, all of which have implications for out-of-pocket costs.

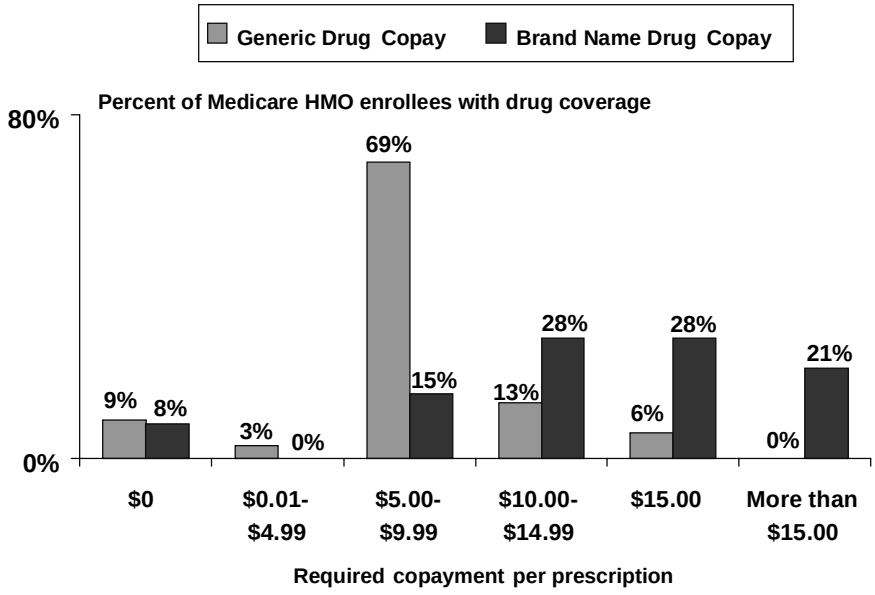
Copayments

Plans that offer prescription drug benefits in their "basic plan" typically require a fixed copayment per prescription filled (usually for a 30-day period) and the level of that payment differs by whether the drug is a generic or a brand name.

Nine out of ten enrollees offered a prescription drug benefit are in HMOs requiring some copayment for each generic prescription filled in 1999. Most (69 percent of enrollees) are enrolled in HMOs charging between $5 and $10 per generic prescription. The average copayment requirement in "basic plans" is $6.42 per generic prescription (Exhibit 3)

Medicare HMOs tend to charge higher copayments for brand name prescription drugs than for generic drugs. The majority (56 percent) of beneficiaries are in plans charging between $10 and $15 for brand name prescription drugs under their "basic" package. An additional 21 percent are charged more than $15 per brand name prescription. On average, beneficiaries are charged a $13.15 copayment per brand name prescription, more than twice the average copayment for generics. While 23 percent of HMO enrollees pay less than $10 per prescription for brand name drugs, 81 percent are charged less than $10 per prescription for generic drugs as part of the "basic" benefits package.

Exhibit 3: Comparison of Prescription Drug Copayments Required for Generic and Brand Name Drugs, 1999

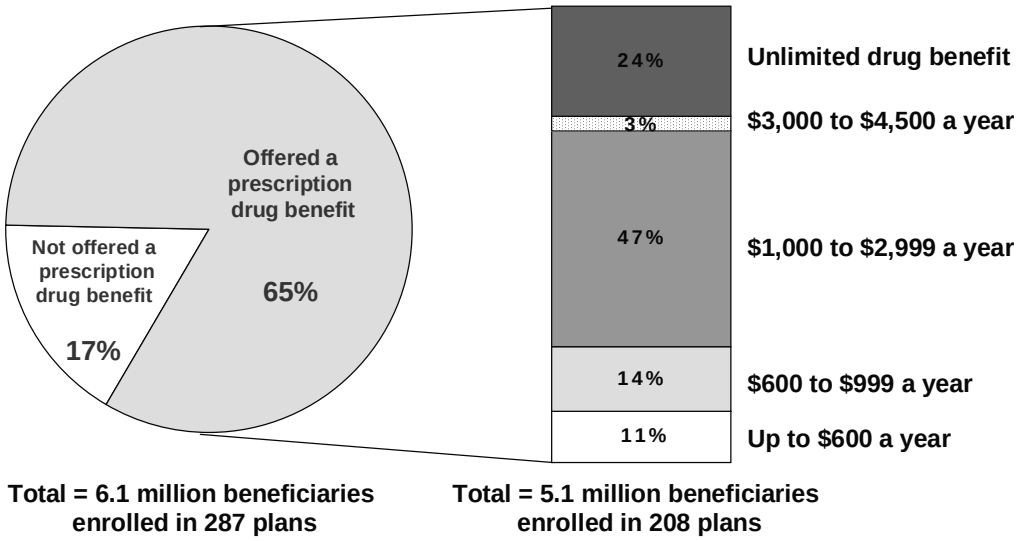


Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999. Among HMOs that offer a drug benefit in their "basic plan," mean generic copayment $6.42 (4.97 million beneficiaries enrolled in 198 plans); mean brand copayment: $13.15 (4.80 million beneficiaries in 192 plans); 5.95 million Medicare beneficiaries enrolled in 279 plans.

Maximum Limits

In addition to copayment requirements, HMOs typically impose maximum quarterly or annual limits on payments for drugs, above the beneficiary copayments. Exhibit 4 shows that 24 percent of enrollees in HMOs offering a drug benefit have unlimited prescription drug benefits. About 11 percent of beneficiaries with drug coverage are enrolled in HMOs that limit payment for drugs to under $600 a year, in their "basic plan." Fourteen percent are limited to between $600 and $1,000 annually. Forty-eight percent of enrollees with drug coverage face a limit between $1,000 and $3,000 for their medications. On average, beneficiaries with drug benefits are limited to about $1,149 of drugs paid by the plan, above any copayment that a beneficiary may be required to pay in 1999. Three percent of enrollees with prescription drug coverage are in HMOs that impose annual limits that are $3,000 to $4,500 a year.

Exhibit 4: Distribution of Medicare Managed Care Enrollees by Annual Maximum Drug Limit in "Basic Plan," 1999



Note: Mean annual limit: $1,149 for those enrolled in a Medicare HMO with annual maximums.
SOURCE: Barents Group LLC and analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999.

Copayment for Dental Exams

Sixty-three percent of enrollees in Medicare HMOs for which data are reported are offered preventive dental benefits. Copayment requirements for dental exams, in HMOs offering dental benefits under their "basic plan," appear to be similar to the physician copayments discussed above. Seventy-nine percent of beneficiaries with preventive dental benefits are enrolled in managed care plans that require enrollees to pay some level of copayment, under the "basic plan," for routine (i.e., preventive) dental exams, with most charged between $5 and $10. The mean payment for dental exams is about $6.38 per visit. Fewer than 15 percent of all enrollees are enrolled in plans charging more than $10 per routine dental exam. However, the range of dental copayments is much wider than for physician copayments - $2 to $50 (Exhibit 5).

Variation across plans for other dental related services may exist, but cannot be determined from the Medicare Compare database. All versions of the database through July 1999 only reported whether preventive dental services were offered, what (if any) copayments were required for preventive visits, and whether "other dental services" were offered. Beneficiaries are instructed to contact the plan for details. No information is provided in the Medicare Compare database on whether or not plans cover dentures, presumably a benefit of interest to the Medicare population.

Hearing Care Benefits

Ninety percent of Medicare HMO enrollees for which data exist in Medicare Compare are offered some kind of hearing benefit. This could range from as basic of a benefit as coverage for aural exams, to coverage for hearing aids. Thirty-five percent of Medicare HMO members enrolled in HMOs offering hearing benefits in their "basic plan" are not charged a copayment for routine hearing exams, while most who are charged pay between $5 and $10 – similar to the copayments for other office visits (physician and dentist). The average payment across all beneficiaries is about $5.41. Only 12 percent of beneficiaries are charged more than $10 for hearing exams (Exhibit 5).

Exhibit 5: Percent of Enrollees in HMOs, by Copayment Charged Per Dental and Hearing Visit Under the "Basic Plan," 1999

		Required Copayment Per Visit					
		$0	Up to $5	$5	$6 to $10	Greater than $10	Total
Percent of HMO Enrollees by Dental Exam Copayment Charged		26%	4%	38%	18%	13%	100%
Mean Copayment	$6.38						
Minimum Copayment	$0						
Maximum Copayment	$50.00						
Number of Enrollees	3,472,566						
Number of Plans	96						
Percent of HMO Enrollees by Hearing Exam Copayment Charged		35%	5%	31%	17%	12%	100%
Mean Copayment	$5.41						
Minimum Copayment	$0						
Maximum Copayment	$25.00						
Number of Enrollees	5,381,654						
Number of Plans	227						

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999.

Hearing aid coverage can take many different forms. Some HMOs offer a predetermined number of hearing aids over a specified time period without limits on the value of the hearing aid (e.g., two hearing aids every two years). Others limit the value of hearing aids without limiting the number of aids (e.g., hearing aids are covered up to $500 over two years). Some HMOs use both types of limits (e.g., two hearing aids over two years are covered up to a maximum value of $500). Only 18 percent of Medicare HMO enrollees are offered "discounts" on hearing aids purchased (e.g., beneficiary pays 65 percent of all hearing aid costs) that may be used in addition to the other restrictions described above or independently.

Vision

The information provided in Medicare Compare on coverage for vision services is limited. Data for all years of Medicare Compare simply indicate whether there is some coverage for eyeglasses and eye exams, without any detail on the frequency of the exam or copayment requirement. It is therefore not possible to examine the depth or generosity of this benefit (i.e., whether eye exams and/or corrective lenses are covered).

VARIATIONS IN BENEFITS ACROSS MARKET AREAS AND HMOS: EFFECTS ON ENROLLEES' OUT-OF-POCKET COSTS

Medicare beneficiaries in different markets and within markets are offered different HMO benefit packages and cost-sharing requirements that can significantly affect their out-of-pocket costs. While the generosity of benefit packages are related, in part, to the level of payments that HMOs receive from Medicare, the generosity of specific benefits can also vary among HMOs within market areas. To highlight the variations in benefits and their implications for Medicare beneficiaries' out-of-pocket costs, we first construct profiles of the range of benefits offered to Medicare beneficiaries by HMOs in six market areas. Then we develop a profile of prescription drug use for a Medicare beneficiary who has multiple medical conditions, requiring high use of prescription drugs, and a profile for a Medicare beneficiary who has moderate use of prescription drugs. These profiles are then used to estimate annual out-of-pocket costs for prescription drugs for these 'hypothetical' beneficiaries if they were enrolled in typical Medicare HMOs with differing levels of prescription drug benefits and limits. In addition, we estimate potential out-of-pocket costs associated with different hearing aid benefit offerings of Medicare HMOs. Results of these analyses illustrate the wide range of differences in benefits offered by Medicare HMOs and the range of out-of-pocket liabilities that Medicare beneficiaries face in choosing among HMOs that offer different benefit packages.

Variations in Premiums and Benefits Offered by Medicare HMOs Within Specific Market Areas

Most (71 percent) Medicare beneficiaries have access to at least one Medicare HMO, and the majority of Medicare beneficiaries have access to two or more HMOs. Twenty-five percent of Medicare beneficiaries had access to six or more HMOs (Exhibit 6). Thus, for most Medicare beneficiaries, choosing an HMO can require obtaining information from several HMOs and comparing their various benefit offerings.

Exhibit 6: Availability of Medicare HMOs for Medicare Beneficiaries, 1998

Number of HMOs Serving County	Number of Counties	Number of Medicare Beneficiaries in County (millions)	Share of Total Medicare Beneficiaries
No plans	2,305	11.6	29%
1 plan	379	4.1	10%
2 - 5 plans	445	14.1	36%
6 - 9 plans	70	7.1	18%
10 or more plans	10	2.8	7%
Total	**3,209**	**39.7**	**100%**

Source: HCFA, *Market Penetration Report*, March 1999 and HCFA, *Medicare Managed Care Contract Service Areas*, April 1999

To illustrate variations in “basic plan" benefits offered to Medicare beneficiaries, we have used the Medicare Compare data to present the ranges in premiums and copayment amounts that exist within five counties from around the nation that (as of March 1999) have a large number of Medicare beneficiaries and high levels of Medicare HMO enrollment (Exhibit 7). There is substantial variation in “basic plan” benefits offered in these counties for most of the benefits considered. In addition, some HMOs offer “high option” packages, as well as the “basic plan," increasing the number of choices and comparisons necessary.

In Los Angeles County, California, 12 Medicare HMOs were serving Medicare beneficiaries in 1999. While all of these HMOs offered supplemental benefits without charging their enrollees a supplemental premium, there were significant variations in enrollees’ potential out-of-pocket costs depending on which Medicare HMO they joined. Physician office visit copayments ranged from $0 to $5 in these plans and dental examination copayments ranged from $0 to $30. The greatest variation and complexity in benefit structure is observed for prescription drug coverage and for hearing aid limits. Copayments for generic drugs in these 12 HMOs ranged from $0 to $7 for a 30 day prescription. For brand name drugs, the copayments ranged from $5 to $20. Limits on maximum prescription drug payments by the HMOs ranged from ‘unlimited’ to a maximum of $2000 annually. The hearing aid benefit was comparably complicated, with one plan covering 65 percent of the costs of all hearing aids purchased by enrollees and other plans limiting the benefit to a maximum of $250 every three years.

By comparison, in Cook County, Illinois, Medicare beneficiaries are offered less generous benefit packages and may need to pay a supplemental premium to the HMO to obtain these supplemental benefits. The range of copayment requirements for physician office visits is higher in Cook County than in Los Angeles County -- up to $10 for primary care physician visits and $15 for specialist physician visits. Similarly, the copayment for generic and brand name prescription drugs is higher in Cook County and one Medicare HMO does not offer any prescription drug benefit. Maximum limits for HMO payments for prescription drugs range from ‘unlimited’ to a maximum of only $600 annually. The hearing aid benefit offered by Cook County HMOs is more comparable across HMOs, ranging from a copayment requirement of between 70 and 80 percent of hearing aid costs.

The comparisons in Exhibit 7, within market area and across market areas, illustrate the complexity of choices available to Medicare beneficiaries and the potential for significant differences in out-of-pocket liabilities that beneficiaries face depending on where they live and the specific Medicare HMO that they choose. In the next section, we provide some illustrative examples of out-of-pocket costs that would be incurred by a ‘typical’ Medicare beneficiary with specific needs for prescription drugs and for hearing aids, depending on the benefit structure offered by her HMO. We limit this illustration to examples of prescription drugs and hearing aids because of the wide range of differences observed among HMOs in the structure of these specific benefit offerings.

Exhibit 7: Comparison of HMO Premiums and Benefit Copayment Amounts for Basic Benefit Package, Selected Counties, 1999

	Los Angeles, CA	Dade, FL	Maricopa, AZ	Cook, IL	Allegheny, PA	King, WA
Number of active HMOs	12	10	9	6	5	7[a]
Monthly supplemental premiums	$0	$0	$0	$0 - $63	$0 - $13	$0 - $29
Physician Copays						
Primary care physician copay per visit	$0 - $5	$0	$3 - $7	$0 - $10	$5 - $10	$0 - $5
Specialist copay per visit	$0 - $5	$0	$5 - $7	$0 - $15	$0 - $10	$0 - $5
Dental exam copay	$0 - $30	$0 - $15	$0 - $5	$0 - $18	Benefit not offered for all but one plan charging $5	Benefit not offered
Drug Benefit						
Generic drug copay per prescription	$0 - $7	$0	$3 - $7	$5 - $10 for all plans except one plan not offering benefit.	$5 - $12 for all plans except one plan not offering benefit.	Benefit not offered
Brand name drug copay per prescription	$5 - $20	$0	$5 - $15	$10 - $15 for all plans except one plan not offering benefit.	$10 - $12 for all plans except one plan not offering benefit.	Benefit not offered
Drug benefit limits	Unlimited or $2,000 - $4,500 for those imposing limit	$2,400 for one plan, no limits on all other plans	Unlimited or $1,500 - $3,000 for those imposing limit	Unlimited or $600 - $1,000 for those imposing limit. One plan does not offer.	$1,000 - $1,500 for all plans except one plan not offering benefit.	Benefit not offered
Hearing Benefit						
Hearing exam copay	$0 - $5	$0 - $25	$0	$0 - $15	$0 - $10	$0 - $5
Hearing aid limit	$250/3yrs - $600/3yrs except one plan charging 65% of all hearing aids	$100/yr - $120/yr except on plan not offering benefit	$600/3yrs - $700/3yrs	70% - 80% copay, no limit	$500/2yrs - $500/3yrs	$250/2yrs

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999*.

a. Eight HMOs operate in King County Washington, however one HMO is open to military retirees only.

Illustrative Examples of the Effect of Variations in Generosity of HMO Benefits on Enrollees' Out-of-Pocket Costs for Prescription Drugs and Hearing Aids

In this section, we develop hypothetical examples of Medicare beneficiaries' use of prescription drugs and of hearing aids and evaluate the out-of-pocket costs associated with coverage that would be offered by 'typical' HMO packages of benefits.

Illustrative Examples for Prescription Drug Coverage

To illustrate how the variation in drug benefits may affect enrollees, we have constructed profiles of Medicare beneficiary drug use and estimated out-of-pocket liability under "typical" plans that vary in generosity of their prescription drug benefits. In the first example, we profile a "high" user patient who is prescribed drugs to treat diabetes, hypertension, stomach ulcers, high cholesterol, and anxiety/depression. The profile below presents the drugs used to treat these conditions, their therapeutic categories, the actual retail price in a non-metropolitan Midwest community, and whether or not they are brand name drugs (Exhibit 8).

Exhibit 8: Prescription Profile for Beneficiary with High Prescription Drug Use, 1999

Drug	Therapeutic Category	Retail Price per Month	Brand or Generic
Relafen	NSAID arthritic drug	$71.99	Brand
Axid	Stomach acid blocker	$25.79	Brand
Paxil	Antidepressant	$67.49	Brand
Prilosec	Antiulcerant	$53.69	Brand
Vaseteric	High blood pressure/diuretic	$70.00	Brand
Rezulin	Antidiabetic	$79.59	Brand
Verapamil	High blood pressure	$16.99	Generic
Baycol	Cholesterol reducer	$39.99	Brand
Cardura	High blood pressure	$71.00	Brand
Total Drug Costs:			
	Monthly	**$496.53**	
	Annually	**$5,958.36**	

Source: Barents Group LLC

Below are four actual plans available to Medicare beneficiaries (Exhibit 9). They were chosen because their features (copayments and maximum limits) are typical of Medicare HMOs throughout the country, illustrating different degrees of generosity for drug benefits. Generosity is defined in terms of the maximum amount that the plan will pay annually for prescription drugs per beneficiary, and the copayments required for each generic and brand prescription.

Exhibit 9: HMO Prescription Drug Coverage, by Level of Generosity, 1999

HMO	Level of Generosity	Drug Maximum	Generic Copay	Brand Copay
HMO A	Least generous	$600	$7	$12
HMO B	Less generous	$1,000	$5	$15
HMO C	More generous	$3,000	$5	$10
HMO D	Most generous	None (unlimited benefit)	$5	$10

Source: Barents Group LLC analysis of HCFA, Medicare Compare 1999

Monthly and annual estimates of both HMO and beneficiary payments for the specified drugs are presented in Exhibit 10, as well as the number of months it would take for the beneficiary to "max out" on their drug benefits, after which the beneficiary is liable for 100 percent of drug costs.

Neither the results below nor in the next example include information on whether the HMO maintains a drug formulary. Under some formularies, it would be possible that the beneficiary might not have coverage for one or more of the prescribed medications and would be required to use other, potentially less effective medications, or to pay for the non-formulary medication out-of-pocket.

Exhibit 10: Comparison of HMO and Beneficiary Costs Under Each Plan for High Prescription Drug Utilization, 1999

HMO	Level of Generosity	HMO Share		Beneficiary Copay		Month in which Maximum is Reached (100% Beneficiary Cost Sharing)
		Monthly	Annually	Monthly	Annually	
HMO A	Least generous	$389	$600	$108	$5,358	2
HMO B	Less generous	$319	$1,000	$125	$4,325	4
HMO C	More generous	$407	$3,000	$90	$2,958	8
HMO D	Most generous	$407	$4,878	$90	$1,080	No Maxiumum

Source: Barents Group LLC

In the 'least generous' HMO, with a $600 maximum, this Medicare beneficiary with high prescription drug use would 'max out' of prescription drug benefits in the second month and would pay $5,358 out-of pocket of the total costs of $5,958. In the "more generous" HMO, that imposes a $3,000 annual maximum, the beneficiary's out-of-pocket liability would be $2,958 and coverage would be exhausted in the eighth month. A 'most generous' HMO – with no maximum limits' - would pay $4,878 of the total prescription drug costs, leaving the beneficiary with an out-

of-pocket liability of $1,080 entirely comprised of copayments. There is a $4,300 difference in beneficiary out-of-pocket liability between the "most generous" HMO (HMO D) and the "least generous" (HMO A).

As a second example, we present information for a hypothetical beneficiary with more moderate drug needs for treatment of high blood pressure, Type II diabetes, and high cholesterol (Exhibit 11).

Exhibit 11: Prescription Profile for a Beneficiary with Moderate Prescription Drug Use, 1999

Drug	Therapeutic Category	Retail Price per Month	Brand or Generic
Vaseteric	High blood pressure/diuretic	$70.00	Brand
Rezulin	Antidiabetic	$79.59	Brand
Verapamil	High blood pressure	$16.99	Generic
Baycol	Cholesterol reducer	$39.99	Brand
Cardura	High blood pressure	$71.00	Brand
Total Drug Costs			
	Monthly	**$277.57**	
	Annual	**$3,330.84**	

Source: Barents Group LLC

Under the 'least generous' HMO, this hypothetical beneficiary would exhaust their prescription drug coverage in the third month and would incur $2,731 in out-of-pocket costs annually (Exhibit 12). Under the 'more generous' and the 'most generous' HMOs, the beneficiary would have coverage for prescription drugs for the full year and would pay only $600 in out-of-pocket costs annually - a $2,131 difference in out-of-pocket liability between the "least" and "most generous" HMO.[8]

[8] It is interesting, also, to examine the findings in the context of the Administration's recent proposal to add a prescription drug benefit to Medicare. In the first year of implementation, the Administration's plan would pay a maximum of $1,000 -- 50 percent of an individual beneficiary's prescription drug costs up to $2,000, with the beneficiary responsible for $1,000 in co-payments and for all prescription drug costs that exceeded $2,000. For the hypothetical "moderate use" Medicare beneficiary in our illustration, with over $3,000 in annual prescription drug costs, HMO package A would be less generous than the Administration's proposal and HMO packages B, C, and D would be more generous.

Exhibit 12: Comparison of HMO and Beneficiary Costs Under Each Plan for Moderate Prescription Drug Utilization, 1999

HMO	Level of Generosity	HMO Share		Beneficiary Copay		Months in which Maximum is Reached (100% Beneficiary Cost Sharing)
		Monthly	Annually	Monthly	Annually	
HMO A	Least generous	$218	$600	$60	$2,731	3
HMO B	Less generous	$198	$1,000	$80	$2,341	6
HMO C	More generous	$228	$2,731	$50	$600	Not Reached
HMO D	Most generous	$228	$2,731	$50	$600	No Maximum

Source: Barents Group LLC analysis

Illustrative Example of Hearing Aid Coverage

An illustration of variations in out-of-pocket liability under different HMO hearing aid benefit structures for a beneficiary wishing to purchase two hearing aids valued at $1,100 apiece, a typical hearing aid purchase, is provided in Exhibit 13.[9]

Exhibit 13: Example Cost Sharing Arrangements for a Hypothetical Beneficiary Purchase of Two Hearing Aids for $1,100 Each

HMO	HMO Limit	HMO Coverage	Beneficiary Liability
HMO A	No coverage	$0	$2,200
HMO B	HMO will pay for hearing aids up to $750 total	$750	$1,450
HMO C	HMO will pay 35 percent of all hearing aid costs.	$770	$1,430
HMO D	Limited to one hearing aid a year	$1,100	$1,100

Source: Barengs Group LLC analysis of HCFA, Medicare Compare 1999

As is the case for prescription drugs, there is variation in beneficiary liability for the same hearing aid needs across different HMOs. In this hypothetical example, a beneficiary requiring two hearing aids valued at $2,200 total would be best served under HMO D, which would pay the full amount for one hearing aid per year.

[9] See Kochkin, Sergei. "Baby Boomers Spur Growth in Potential Market, but Penetration Rate Declines," *The Hearing Journal*, January 1999; Vol. 52:1, for further discussion.

DISCUSSION

By law, all Medicare HMOs must offer basic Medicare benefits. Most offer a complex package of supplemental benefits, in addition to required Medicare benefits. These supplemental benefits are attractive to Medicare beneficiaries who often face significant out-of-pocket liability for these services. The analysis of selected benefits offered by Medicare HMOs in 1999 indicates that there are wide variations in the coverage for supplemental benefits that are offered. Medicare beneficiaries who must choose among HMOs and between HMOs and other supplemental insurance policies are faced with a complicated task in evaluating their choices.

The level of Medicare HMO prescription drug benefits ranges from very limited coverage to quite generous coverage. At a time when prescription drug costs are rising rapidly, the more generous Medicare HMOs may be the best alternative available to many Medicare beneficiaries facing high out-of-pocket costs for these products. The rapid increases in prescription drug costs, coupled with reductions in the growth of Medicare payments to plans, may place increasing financial pressures on Medicare HMOs, potentially jeopardizing the availability of relatively generous, affordable drug coverage under Medicare HMOs in the future.

Results of the study provide useful information for the current policy discussions about the complexities of choices available to Medicare beneficiaries and the information they need to make appropriate choices. In addition, it highlights the uneven availability of highly desired benefits under Medicare HMOs throughout the nation.

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025

650-854-9400 Facsimile: 650-854-4800

Washington Office:
1450 G Street N.W., Suite 250
Washington, DC 20005

202-347-5270 Facsimile: 202-347-5274

http://www.kff.org

Additional free copies of this report (#1511) are available from our web site
or by calling our publications request line at 800-656-4533.